MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

(70)

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Compton (No. 04687 St.; Ward)

2 FULL NAME James Thomas Abell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1837 (Year)

7 AGE: 81 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): St Marys Co Md

PARENTS

10 NAME OF FATHER: James Abell

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Clara Bowles

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Perry Abell

(Address) Compton Md

15 Filed Mar 30, 1919 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar 29 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1919, to Mar 29, 1919, that I last saw h~ alive on Mar 28, 1919, and that death occurred on the date stated above, at 4a m.

The CAUSE OF DEATH * was as follows:

Gastric Atrophy

Subacute C.w.B.P. (Duration) 1 yrs. 1 mos. 10 ds.

Contributory / Secondary Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G F Greenwell M. D.

Mar 30 1919 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In this State, ... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Town Cemetery — DATE OF BURIAL: Mar 31 1919

20 UNDERTAKER: Wm T C Mattingley — ADDRESS: Leonardtown Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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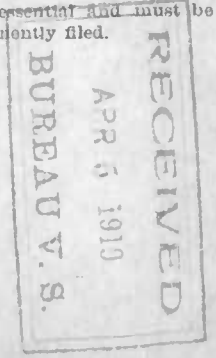

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04688 (28)

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Compton (No. ....., ... St.; ..... Ward)

2 FULL NAME Annie Theresa Barnes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Colored	Single

6 DATE OF BIRTH ..... (Month) ..... (Day), 1903 (Year)

7 AGE 15 yrs. 10 mos. — ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work schoolgirl
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) St Marys Co

PARENTS

10 NAME OF FATHER Thomas Edgar Bond

11 BIRTHPLACE OF FATHER (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Eliza Ann Gibson

13 BIRTHPLACE OF MOTHER (State or country) St Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Edgar Bond

(Address) Compton

15 Filed Mar 13, 1919 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 12, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 6th, 1919, to Mar 12, 1919, that I last saw h[illegible] alive on Mar 11, 1919, and that death occurred on the date stated above, at 11 0 m.

The CAUSE OF DEATH * was as follows:

Tuberculosis

(Duration) ..... yrs. ..... mos. 32 ds.

Contributory Secondary Fibroid Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Mar 13, 1919 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Town Cemetery	Mar 14, 1919
20 UNDERTAKER	**ADDRESS**
Wm C Mattingly	Leonardtown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningcs, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetonus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 5 1910
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04689 (92)

Registration Dist. No. 280.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Marys

Village or City Park Hall Maryland (No. ....., ... St.; ..... Ward)

2 FULL NAME John Thomas Beal

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Single

6 DATE OF BIRTH: April (Month) 15 (Day), 1915 (Year)

7 AGE: Three yrs. 11 mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Peter James Beal

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Alice Hawkins

13 BIRTHPLACE OF MOTHER (State or country): Washington, D. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Hodgdon M.D.

(Address) California Maryland

15 Filed Mch. 29, 1919 E. E. Burch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 28 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1919, to March 25, 1919, that I last saw him alive on March 25, 1919, and that death occurred on the date stated above, at 9P m.

The CAUSE OF DEATH * was as follows:

1st Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Hodgdon, M. D.

March 29, 1919 (Address) California Maryland

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Agatha Church DATE OF BURIAL: 3-30, 1919

20 UNDERTAKER: E. L. Robinson ADDRESS: Damascus

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be knowu. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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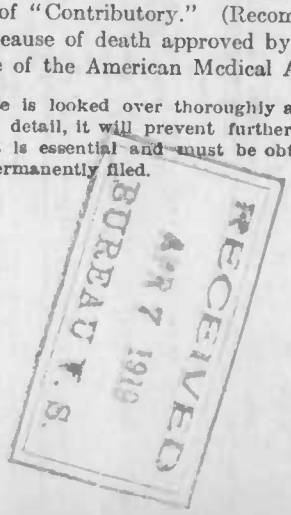

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

(28)

04690

Registration Dist. No. 283

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Marys

Village or City Clements (No. ....., ... St.; ..... Ward)

2 FULL NAME Catherine N. Bowles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug. (Month) 28 (Day), 1876 (Year)

7 AGE: 42 yrs. 6 mos. 28 ds. If LESS than 1 day ..... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Stuart

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Attaway Tennison

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. J. Bowles

(Address) Clements

15 Filed Mch. 26, 1919 L. B. Johnson Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mch (Month) 25 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mch. 4, 1919, to Mch. 25, 1919, that I last saw h[illegible] alive on Mch. 4, 1919, and that death occurred on the date stated above, at 24 m.

The CAUSE OF DEATH * was as follows:

Tuberculosis of Lungs

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory
Secondary

(Duration) ..... yrs. ..... mos. ..... ds

(Signed) L. B. Johnson, M. D.

Mch. 4 1919 (Address) Morganza

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Joseph's — DATE OF BURIAL: Mch. 27, 1919

20 UNDERTAKER: Welch Bros. — ADDRESS: Chaptico

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (c. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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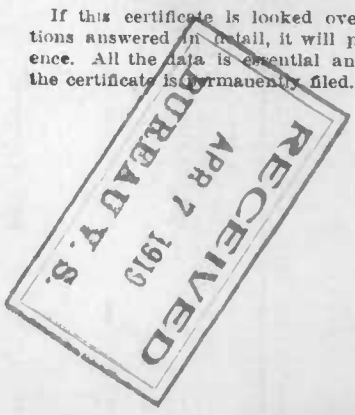

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

04691

(64)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Mary's

Village or City Laurel Grove (No. ....., ... St.; ..... Ward)

2 FULL NAME Susan Jane Brown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan 3 (Month) (Day), 1827 (Year)

7 AGE: 92 yrs. 2 mos. 2 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Harry Brown

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan Simonile

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilson Brown

(Address) Laurel Grove

15 Filed Mar 5, 1919 L. B. Johnson Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 5 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...

that I last saw h... alive on ....., 191...

and that death occurred on the date stated above, at 5-9 m

The CAUSE OF DEATH * was as follows:

No Physician in attendance

Cerebro Apoplexy

(Duration) ... yrs. ... mos. 8 d

Contributory .....
Secondary .....
(Duration) ... yrs. ... mos. ... d

(Signed) L. B. Johnson Asst. M.

Mar 5, 1919 (Address) Morganza

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ...

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Golden Cemetery

DATE OF BURIAL: Mch 6, 1919

20 UNDERTAKER: B. B. Lee

ADDRESS: Morganza

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healtbfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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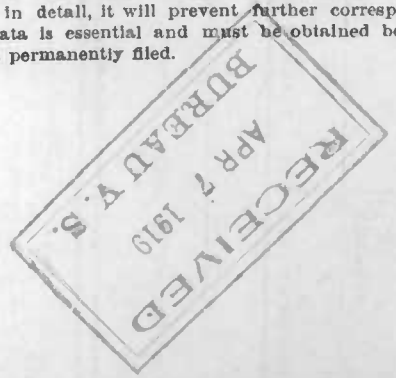

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

County St Marys

0462 (89)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 282

Village or City Leonardtown (No. ..... , ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lydia Ann Fennell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	W	S

6 DATE OF BIRTH Oct 31, 1914 (Month) (Day) (Year)

7 AGE — yrs. 4 mos. 27 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) St Marys Co

PARENTS

10 NAME OF FATHER Jacob Fennell

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Sarah Agnes Vallaughan

13 BIRTHPLACE OF MOTHER (State or country) St Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Fennell

(Address) Palmers Md

15 Filed Mar 29 1919 F F [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 28, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 26, 1919, to Mar 28, 1919, that I last saw h[illegible] alive on Mar 27, 1919, and that death occurred on the date stated above, at 11 a m.

The CAUSE OF DEATH * was as follows:

Capillary Bronchitis

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory Secondary Malnutrition

(Duration) ..... yrs. 4 mos. — ds.

(Signed) F F Greenwell M. D.

Mar 28 1919 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL St Inigoes Cemetery

DATE OF BURIAL Mar 29, 1919

20 UNDERTAKER A. J. Mattingley

ADDRESS Britton

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 6 1909
BUREAU U. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH NON-FADING INK—THIS IS A PERMANENT RECORD

N B Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2-6

(91)

1 PLACE OF DEATH

County St. Mary's

Village or City Blakistons (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME alice Luna Gardner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
female	white	Single

6 DATE OF BIRTH: 9 (Month) 18 (Day), 1913 (Year)

7 AGE: 5 yrs. 6 mos. 4 ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): md

PARENTS

10 NAME OF FATHER: John H. Gardner

11 BIRTHPLACE OF FATHER (State or country): md

12 MAIDEN NAME OF MOTHER: Mamie A. Hubbard

13 BIRTHPLACE OF MOTHER (State or country): md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Gardner

(Address) Blakistons md

15 Filed 3-20, 19[illegible] R V Palmer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 9 (Month) 20 (Day), 1918 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 3-16, 1918, to 3-20, 1918, that I last saw h[illegible] alive on 3-19, 1918, and that death occurred on the date stated above, at [illegible] m.

The CAUSE OF DEATH * was as follows:

Bronchio-pneumonia

(Duration) ____ yrs. ____ mos. 5 ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R V Palmer, M. D.

3-20-, 1918 (Address) Abell md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sacred Heart	3-20-, 1918
20 UNDERTAKER	ADDRESS
Empire Home	Abell

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 8 yrs.).* For persons who have no occupation whatever write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of [illegible] (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning. Struck by railway train—accident. Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

[illegible] of this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 7 1919
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04694

(151)

Registration Dist. No. 187

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Jarboesville (No. ....., ... St.; ..... Ward)

2 FULL NAME Mary S Gorden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single

6 DATE OF BIRTH March 24, 1919 (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. 7 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER John Grover Gorden

11 BIRTHPLACE OF FATHER (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Annie Sumerville

13 BIRTHPLACE OF MOTHER (State or country) St Marys Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Grover Gorden

(Address) Jarboesville Md

15 Filed March 30, 1919 C. Wesley Magill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 30, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

unknown

there was no Dr

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Wesley Magill Jr R. M.D.

March 30 1919 (Address) Great Mills Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL St Nicholas Church

DATE OF BURIAL Mar 31, 1919

20 UNDERTAKER John Grover Gorden

ADDRESS Jarboesville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 4 1919
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 281

04655 (120)

1 PLACE OF DEATH

County St Marys

Village or City Piney Point (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William T Goad

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	black	married

6 DATE OF BIRTH: not known (Month) (Day), 1864 (Year)

7 AGE: 55 yrs. not known mos. ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: waiter at Hotel.
(b) General nature of industry business, or establishment in which employed (or employer): " "

9 BIRTHPLACE (State or country): St Marys Co Md

PARENTS

10 NAME OF FATHER: Thomas Goad

11 BIRTHPLACE OF FATHER (State or country): St Marys Co Md

12 MAIDEN NAME OF MOTHER: Addanna Taylor

13 BIRTHPLACE OF MOTHER (State or country): St Marys Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEOGE

(Informant) Joseph Fateman

(Address) Valley Lee

15 Filed March 12, 1919 L P Spicer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 11 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1919, to Mar 11, 1919, that I last saw him alive on Feb 28 Feb, 1919, and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis interstitial
Bright Disease

(Duration) 1 yrs. 2 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) C. A. Brown M. D.

Mar 12, 1919 (Address) Red Gate Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Marks Church Valley Lee

DATE OF BURIAL: Mar 12, 1919

20 UNDERTAKER: Louis Clark

ADDRESS: Great Mills

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 4 1913
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04696

(91)

Registration Dist. No. 2 84

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Charlotte Hall (No. ....., ... St.; ..... Ward)

2 FULL NAME David Robt Hawkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): S

6 DATE OF BIRTH: Jan (Month) 27 (Day), 1914 (Year)

7 AGE: ..... yrs. 1 mos. 14 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country): St Marys Co

PARENTS

10 NAME OF FATHER: Bernard E. Hawkins

11 BIRTHPLACE OF FATHER (State or country): St Marys Co

12 MAIDEN NAME OF MOTHER: Jamie E. Green

13 BIRTHPLACE OF MOTHER (State or country): St Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bernard E Hawkins

(Address) Charlotte Hall

15 Filed March 15, 1919 Levin J Sothoron
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 14 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Did not attend baby, 191...,

that I last saw h ..... alive on ....., 191...,

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

from investigation baby died from Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Levin J Sothoron, M. D.

March 15, 1919 (Address) Mechanicsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St Joseph Cemetery

DATE OF BURIAL: March 15, 1919

20 UNDERTAKER: Charles Butler

ADDRESS: Charlotte Hall

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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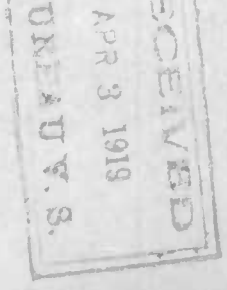

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

04697

(2)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 281

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Mary's

Village or City St. George's Island (No. ....., ... St.; ..... Ward)

2 FULL NAME Maurice Henry Jones Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 26, 1919 (Month) (Day) (Year)

7 AGE: Stillbirth ..... yrs. — mos. — ds.

If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): St. George's Island, Md.

PARENTS

10 NAME OF FATHER: Maurice Henry Jones

11 BIRTHPLACE OF FATHER (State or country): Chance, Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bessie C. Jones,

(Address) St. George's Island, Md.

15 Filed 3-27, 1919 C. B. Graham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 26, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That ~~I attended deceased from~~ Child was born ~~in~~ dead March 26, 1919

~~that I last saw him alive on~~ ....., ~~191~~

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH * was as follows:

Stillbirth

(Duration) — yrs. — mos. — ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. Horker Lynch, M. D.

March 27, 1919. (Address) Valley Lee, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Methodist Church

DATE OF BURIAL: March 27, 1919

20 UNDERTAKER: G. [illegible] Chesser

ADDRESS: St. George's Island, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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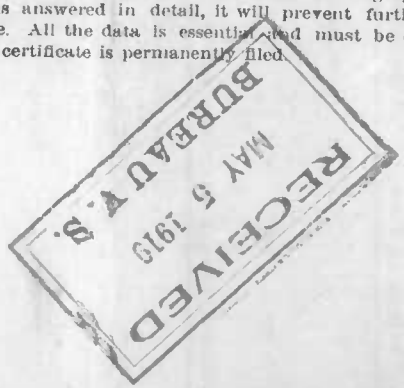

MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

(157)

04698

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Leonardtown (No. ____, ____ St.; ____ Ward)

2 FULL NAME John Klear

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April (Month) ____ (Day), 1 (Year)

7 AGE: 63 yrs. 11 mos. — ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): ____

9 BIRTHPLACE (State or country): Ohio

PARENTS

10 NAME OF FATHER: Peter Klear

11 BIRTHPLACE OF FATHER (State or country): unknown

12 MAIDEN NAME OF MOTHER: Mary Kestle

13 BIRTHPLACE OF MOTHER (State or country): unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Klear

(Address) Leonardtown

15 Filed Mar 23 1919 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mar (Month) 22 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from did not attend him, 191__, to ____, 191__, that I last saw him ~~alive~~ dead on Mar 22, 1919, and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

Suicide by hanging

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) F F Greenwell, M. D.

Mar 23, 1919 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL: St Aloysius Cemetery

DATE OF BURIAL: Mar 23, 1919

20 UNDERTAKER: Wm C Mattingly

ADDRESS: Leonardtown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04669

(151)

Registration Dist. No. 287

1 PLACE OF DEATH

County St Marys

Village or City Great Mills (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Fannie Mason

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fml	Black	single

6 DATE OF BIRTH: March 5, 1919 (Month) (Day) (Year)

7 AGE: ____ yrs. ____ mos. 4 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ____
(b) General nature of industry business, or establishment in which employed (or employer) ____

9 BIRTHPLACE (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER: William Nelson Mason

11 BIRTHPLACE OF FATHER (State or country): St Marys Co Md

12 MAIDEN NAME OF MOTHER: Mary Elizabet Thompson

13 BIRTHPLACE OF MOTHER (State or country): St Marys Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Nelson Mason

(Address) Great Mills Md

15 Filed Mar 9, 1919 J. Wesley Magill
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 9, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 191__, to ____, 191__, that I last saw h__ alive on ____, 191__, and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * ~~was as follows:~~

Is unknown
there was no Dr

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory ____
Secondary ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. Wesley Magill M. D.

March 9, 1919 (Address) Great Mills Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Nicholas Church	Mar 9, 1919

20 UNDERTAKER	ADDRESS
William N. Mason	Great Mills Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 5 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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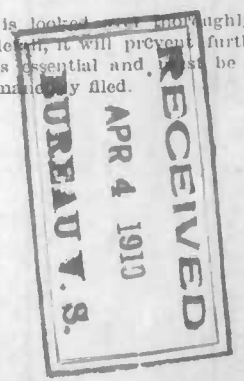

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

0470 (151)

Registration Dist. No. 281

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Marys

Village or City Drayden, (No. , St.; Ward)

2 FULL NAME Agnes Gertrude Millburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 13, 1919 (Month) (Day) (Year)

7 AGE: — yrs. — mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): St. Marys Co. Md.

PARENTS

10 NAME OF FATHER: John Henry Millburn

11 BIRTHPLACE OF FATHER (State or country): St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Allie Russell

13 BIRTHPLACE OF MOTHER (State or country): St. Marys Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Henry Millburn

(Address) Drayden, Md.

15 Filed March 16, 1919 C P Thompson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 16, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1919 to March 16, 1919, that I last saw her alive on March 15, 1919, and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH * was as follows:

Premature birth and lack of vitality

(Duration) — yrs. — mos. 2 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) T. Hooper Lynch M. D.

March 16, 1919 (Address) Valley Lee Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Poplar Hill Church

DATE OF BURIAL: March 17, 1919

20 UNDERTAKER: Richard Nalley

ADDRESS: Drayden Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 4 1919
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04701 (8)

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Brittons (No. ....., ... St.; ..... Ward)

2 FULL NAME not named born dead

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH March (Month) 9 (Day), 1919 (Year)

7 AGE born dead ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. DR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) "

9 BIRTHPLACE (State or country) St Marys co Md

PARENTS

10 NAME OF FATHER Ernest Ignatius Millburn

11 BIRTHPLACE OF FATHER (State or country) St Marys co Md.

12 MAIDEN NAME OF MOTHER Marie Rosa Lee Adams

13 BIRTHPLACE OF MOTHER (State or country) St Marys co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Ignatius Millburn

(Address) Brittons Md

15 Filed Mar 10, 1919 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 9 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 9, 1919, to Mar 9, 1919, that I last saw him ~~alive~~ dead on Mar 9, 1919, and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows: The child had been dead 20 days in the mother following the mother having influenza which I beleive was the cause. (Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Brown, M. D.

Mar 9, 1919 (Address) Red Gate Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. Is the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Hathaway Place Brittons

DATE OF BURIAL Mar 9, 1919

20 UNDERTAKER Ernest Ignatius Millburn

ADDRESS Brittons

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework;* or *At Home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04702

(151)

Registration Dist. No. 281

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Mary's

Village or City Drayden (No. ..., ... St.; ..... Ward)

2 FULL NAME Mary Stephens Milburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March (Month) 12 (Day), 1919 (Year)

7 AGE: — yrs. — mos. 4 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): St. Mary's Co. Md.

PARENTS

10 NAME OF FATHER: John Henry Milburn

11 BIRTHPLACE OF FATHER (State or country): St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Addie Russell

13 BIRTHPLACE OF MOTHER (State or country): St. Mary's Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Henry Milburn

(Address) Drayden, Md.

15 Filed March 16, 1919 L R Spinzer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 16 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1919, to March 15, 1919, that I last saw her alive on March 15, 1919, and that death occurred on the date stated above, at 28 m.

The CAUSE OF DEATH * was as follows: Premature birth and lack of vitality.

(Duration) — yrs. — mos. 4 ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. Hooper Lynch, M. D.

March 16, 1919 (Address) Valley Lee, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Poplar Hill Church

DATE OF BURIAL: March 17, 1919

20 UNDERTAKER: Richard Nott.

ADDRESS: Drayden Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 4 1919
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

(120)

Registration Dist. No. 287

1 PLACE OF DEATH

County St. Mary's

Village or City Great Mills (No. 04703, St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs Eliza Alevina Owens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: Oct. (Month) 6 (Day), 1863 (Year)

7 AGE: 65 yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. OR ___ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): St. Mary's Co. Md.

PARENTS

10 NAME OF FATHER: Edmond Morris

11 BIRTHPLACE OF FATHER (State or country): St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER: Celista Hammett

13 BIRTHPLACE OF MOTHER (State or country): St. Mary's Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora Elizabeth Potter

(Address) Great Mills, Md.

15 Filed March 19, 1919 Wesley Magill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 17 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1919, to March 17, 1919, that I last saw her alive on March 17, 1919, and that death occurred on the date stated above, at 3.5 m.

The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory
Secondary

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) T. Harper Tyrer, M. D.

March 19, 1919 (Address) Valley Lee, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Nicholas Church	March 19, 1919
20 UNDERTAKER	**ADDRESS**
Ernest Roberson	Cameron, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill,* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles. Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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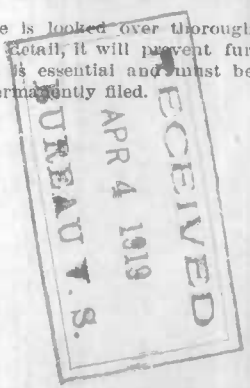

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 284

64705 (113)

1 PLACE OF DEATH

County St Marys

Village or City Mechanicsville (No. ; St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Daniel Podgett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	M

6 DATE OF BIRTH: Dec (Month) 28 (Day), 1869 (Year)

7 AGE: 50 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Charles Co Md.

PARENTS

10 NAME OF FATHER: James Podgett

11 BIRTHPLACE OF FATHER (State or country): Charles Co.

12 MAIDEN NAME OF MOTHER: — Garner

13 BIRTHPLACE OF MOTHER (State or country): Charles Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bradley Podgett

(Address) Mechanicsville

15 Filed Mar 22 1919 Lewis J Gotherson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 22 (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1919, to March 22, 1919, that I last saw h alive on March 20, 1919, and that death occurred on the date stated above, at 4a. m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Liver

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Lewis J Gotherson, M. D.

March 22 1919 (Address) Mechanicsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Josephs Cemetery — DATE OF BURIAL: March 23, 1919

20 UNDERTAKER: Mrs J Wilson Adams — ADDRESS: Mechanicsville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"), *Typhoid fever* (never report "Typhoid pneumonia"), *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident, Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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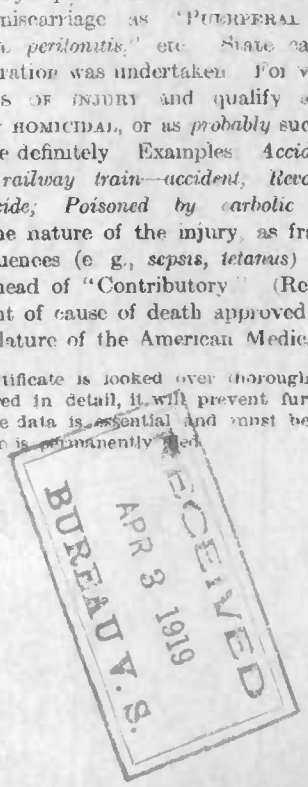

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04705 (28)

Registration Dist. No. 281

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Marys

Village or City Valley Lee, (No. ....., ... St.; ..... Ward)

2 FULL NAME Mrs Sarah Reburn Redman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug 30, 1885 (Month) (Day) (Year)

7 AGE: 34 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): St. Marys Co. Md.

PARENTS

10 NAME OF FATHER: Thomas B. Shelton

11 BIRTHPLACE OF FATHER (State or country): St. Marys Co. Md

12 MAIDEN NAME OF MOTHER: Amanda Posey

13 BIRTHPLACE OF MOTHER (State or country): St. Marys Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John B. Redman

(Address) Valley Lee, Md.

15 Filed March 8, 1919 L P Stinger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 7, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1919, to March 6, 1919, that I last saw her alive on March 6, 1919 and that death occurred on the date stated above, at 10-30 P. m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory .....
Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. Horace Tyrrell, M. D.

March 8, 1919 (Address) Valley Lee, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds.

To this State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Georges R. C. Church

DATE OF BURIAL: March 9, 1919

20 UNDERTAKER: Denis T. Clarke

ADDRESS: Great Mills, Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup."); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 4 1913
BUREAU [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

04708 (8)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 285

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Hollywood (No ____, ____ St.; ____ Ward)

2 FULL NAME Infant Summerville Ind (1)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
female	colored	—

6 DATE OF BIRTH Jan 14 (Month) (Day), 1919 (Year)

7 AGE: born dead yrs. mos. ds. | If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER James Elsie Summerville

11 BIRTHPLACE OF FATHER (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Lucy May Scott

13 BIRTHPLACE OF MOTHER (State or country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Elsie Summerville

(Address) Hollywood Md

15 Filed Jan 15, 1919 — Registrar

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan 14 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 191__, to ____, 191__, that I last saw h[illegible] alive on Jan 14, 1919, and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

Light Injury to Mother

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) F F Greenwell, M. D.

(Address) Leonardtown Jan 15, 1919

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL St Johns Cemetery — DATE OF BURIAL Jan 15, 1919

20 UNDERTAKER Webster Summerville — ADDRESS Hollywood Md

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Sheck," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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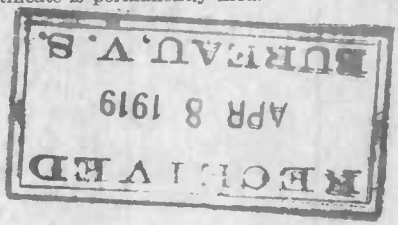

4706/N

5522 (8)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 285

1 PLACE OF DEATH

County St Marys

Village or City Hollywood (No. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Summerville No 2

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colrd

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): —

6 DATE OF BIRTH: Jan 14, 1914 (Month) (Day) (Year)

7 AGE: Born dead yrs. mos. ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St Marys Md

PARENTS

10 NAME OF FATHER James Elain Summerville

11 BIRTHPLACE OF FATHER (State or country) St Marys Md

12 MAIDEN NAME OF MOTHER Lucy Gray Scott

13 BIRTHPLACE OF MOTHER (State or country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Elain Summerville

(Address) Hollywood Md

15 Filed Jan 15, 1914 H G
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 14 (Month) (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw her alive dead on Jan 14, 1914,
and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Injury to Mother

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H F Greenwell M. D.

Jan 15, 1914 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: Jan 15, 1914

20 UNDERTAKER: Webster Summerville — ADDRESS: Hollywood Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

V. S. No. 1.

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH NON-FADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Caneer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

04707

(64)

Registration Dist. No. 287

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Mary

Village or City California (No. ——, —— St.; —— Ward)

2 FULL NAME Chas Turner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Not Known (Month) (Day), 1 (Year)

7 AGE: About 68 yrs. mos. ds. If LESS than 1 day, ... hrs. OR ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Oysterman
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known.

13 BIRTHPLACE OF MOTHER (State or country): Not Known.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Hodgdon M.D.

(Address) California Maryland

15 Filed Mar 21, 1919

Jas. E. Hayward Dept REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 20, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I ~~attended~~ prescribed for deceased from March 19, 1919, to ..., 191..., that I last saw h... alive on ..., 191..., and that death occurred on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage and Hemiplegia

(Duration) ... yrs. ... mos. about one day

Contributory Secondary

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. L. Hodgdon, M. D.

March 21, 1919 (Address) California, Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Nicholas Church

DATE OF BURIAL: Mar. 22, 1919

20 UNDERTAKER: Lewis T. Clarke

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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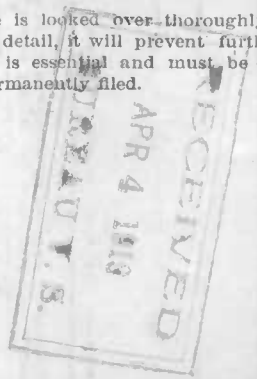

MARGIN RESERVED FOR BINDING

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V. S. No. 1.

04708

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Britton (No. ....., ... St.; ..... Ward)

2 FULL NAME Garrett Hill Gates

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) M

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7 AGE 85 yrs. — mos. — ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) St. Marys Co

PARENTS

10 NAME OF FATHER Dick Hill

11 BIRTHPLACE OF FATHER (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Julia Ann Holmes

13 BIRTHPLACE OF MOTHER (State or country) St Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Gates

(Address) Britton Md

15 Filed Mar 22 1919 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 21 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1919, to Mar 21, 1919, that I last saw her alive on March 21, 1919, and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Chronic Nephritis

(Duration) 8 yrs. — mos. ..... ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Mar 22 1919 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Medleys Neck Cemetery

DATE OF BURIAL Mar 23, 1919

20 UNDERTAKER Wm C Mattingly

ADDRESS Leonardtown

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RECEIVED APR 6 1910 REGISTRAR U. S.